Hospital Sisters
HEALTH SYSTEM

November 25, 2013

TO: **Members of the Health and Medicine Policy Research Group**

FROM: **Larry Schumacher, Chief Operating Officer, HSHS**

RE: **Input on Illinois Concept Paper for 1115 Waiver**

Hospital Sisters Health System (HSHS) appreciates the opportunity to submit comments on "The Path to Transformation: Concept Paper for an 1115 Waiver for Illinois Medicaid (the "Concept Paper").

HSHS is the one of the largest downstate systems in Illinois, including eight hospitals, a multispecialty physician group (HSHS Medical Group), and Prairie Cardiovascular Consultants – all of which serve broad sections of Central and Southern Illinois. We are a healing ministry, guided by the historic mission of the Hospital Sisters of St. Francis – with a special emphasis on the poor and underserved.

HSHS has been pursuing a Care Integration strategy since 2008 with the same goals for patient-centered, coordinated, and efficient care envisioned by Pathway #2 in the Concept paper. This includes a Physician Clinical Integration Network comprised of nearly 800 independent physicians that are collaborating with HSHS in pursuing value-based payment systems. We sponsor 15 Patient-Centered Medical Home pilot sites that use on-site "nurse navigators" to improve care for patients with chronic conditions. HSHS also actively participates in a "Medicaid Collaborative" that is committed to value-based solutions for care to Medicaid patients and rural and downstate geographies. The Collaborative includes HSHS, Central Counties Health Centers, the Southern Illinois University (SIU) School of Medicine, and Southern Illinois Healthcare Foundation.

HSHS commends the State for seeking ways to accelerate the development of a better and more efficient delivery system to meet the needs of our most vulnerable residents, and we offer the following comments on the Concept Paper.

Belleville, IL
St. Elizabeth's Hospital

Breese, IL
St. Joseph's Hospital

Decatur, IL
St. Mary's Hospital

Effingham, IL
St. Anthony's Memorial Hospital

Highland, IL
St. Joseph's Hospital

Litchfield, IL
St. Francis Hospital

Springfield, IL
St. John's Hospital

Streator, IL
St. Mary's Hospital

Chippewa Falls, WI
St. Joseph's Hospital

Eau Claire, WI
Sacred Heart Hospital

Green Bay, WI
St. Mary's Hospital Medical Center
St. Vincent Hospital

Sheboygan, WI
St. Nicholas Hospital

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Ensure that the approach is focused and integrated to avoid a diffusion of effort and funding for a program that is already underfunded. We are very concerned that the Concept Paper attempts to address too many discrete issues and redeploy resources to too many organizations and interests. The result could be a reallocation of scarce resources away from the organizations that are most needed in order to create the "integrated, rational and efficient healthcare delivery system" envisioned by the document. We support an approach that provides better and more efficient care for patients.

Unify and integrate the waiver around the development of integrated delivery systems. The document expresses a compelling vision for investment in organizations that can "…reduce costs and improve quality through the management of care and care transitions and aligned incentives to ensure the right care at the right time in the most appropriate setting." These Integrated Delivery Systems (IDSs) – especially as developed by the physicians, hospitals, and other entities that are actually providing care to patients – hold the most promise for a sustainable Medicaid program. We urge the State to use this concept as a filter and an integrating vision. If any concept in the waiver is not clearly linked to the successful development of IDSs, it should be removed from the approach. Otherwise, the State risks a diffusion of scarce resources and an underinvestment in care transformation.

Invest in the development of IDSs by physicians, hospitals, and the other providers that are best equipped to integrate the delivery of care and achieve sustainable savings rather than short-sighted payment cuts. We appreciate the State's efforts to encourage provider-based IDSs by allowing for Care Coordination Entity (CCE) and Accountable Care Entities (ACE). But these cannot be the only options for transforming delivery systems across Illinois. An IDS must be able to implement practice redesign strategies that are recognized through outcomes-based reimbursement from multiple payers. While organizations like HSHS and the Medicaid Collaborative are actively working to integrate care, we are changing cultures and traditional fee-for-service incentives that have been in place for decades. It will take more than the 18 months allowed under the ACE option, for example, to achieve the significant clinical redesign,

coordination mechanisms, information technology, legal, and cultural changes that are required to take financial risk. This is particularly true in more rural settings of the State where HSHS operates.

Some of the language under "2C: Hospital/Health System Transformation" is encouraging in this regard, and we would like to work with the State to clarify and strengthen concepts such as "incentive-based pools to drive transformation of systems."

We urge the state to invest in a 4 to 5 year "glide path" for organizations to achieve IDS capability through a sequencing of capacity, including such interim steps as adequate care coordination fees (the ACE amounts are currently too low) and shared savings. Otherwise, Medicaid in Illinois is likely to be dominated more by rate reductions and remotely imposed utilization controls rather than true system change. This may result in short-term savings for the state, but not sustainable efficiencies. Our 15 Medical Home pilot sites, for example, are already showing strong evidence of reduced readmissions, reduced ER use, improved blood glucose control for diabetics, and more efficient drug usage. A portion of the resultant savings should help underwrite the added operational expense of this model.

This long-view investment in sustainable system transformation could be pursued through the State Innovation Model Design grant. But to achieve system change across more than just a few geographical pockets, this investment needs to be broadened beyond CCEs and ACEs to include other contracting arrangements. Also, the State needs to allow direct State contracting for provider-based organizations that can meet required standards into all markets, rather than closing off participation only to Managed Care Organizations (MCOs).

Incentivize MCOs to partner with providers on care management and delivery system reform. We recognize that physicians, hospitals, and other providers will often need to partner with MCOs to develop sustainable IDS capabilities as described above. We are very concerned that this will not happen if MCOs rely on simple fee-for-service rate reductions and utilization reviews. These incentives (which would apply to all organizations working toward financial risk

– not just MCOs) could include requirements for shared savings models, quality targets, performance bonds, medical loss ratios, and rate floors. A rate floor, for example, would ensure minimal funding for enrollees who really need hospital care while encouraging MCO/provider partnerships that can achieve savings through better coordinated care, improved enrollee health, and reduced hospitalizations.

Consider alternatives to the uncompensated care pool or "access assurance pool." We are awaiting more detail to fully understand the scale and scope of this concept, but we are very concerned that it could result only in a shifting of dollars without contributing to IDS development and more efficient care. We cannot support another program that simply replaces one complex hospital payment system in which dollars do not follow the patient (e.g. "current fixed supplemental payment programs") with another such system that still fails to direct payments based on the volume and acuity of patients served. We understand that one purpose of the pool is to protect payments from the Upper Payment Limit that could result from shifting of Medicaid enrollees into managed care. Before moving to an uncertain solution, we urge the State to debate and consider all solutions that reduce the risk to the UPL. These include: Moving all supplemental payments into fee-for-service rates (as in most other states), Revising State law to extend the current provider tax without modification, or Requesting a waiver to apply all current Medicaid payments to the fee for service and managed care populations. Each of these options represents a viable solution to the UPL. All solutions should be considered in terms of their relative risk to the current program that provides significant benefit to both Providers and the State in an open and transparent process.

Ensure that the workforce initiatives under Pathway #4 reflect both the needs and provider capabilities of downstate Illinois. HSHS sponsors significant Graduate Medical Education programs with Southern Illinois University School of Medicine, St Louis University and other schools, with a particular expertise and emphasis in family medicine, rural and primary care issues. We also sponsor the St. John's College of Nursing in Springfield, one of many downstate

organizations that are contributing to rural and downstate solutions, including innovations aimed at midlevel professionals and training for the workforce needs of IDSs, Medical Homes, and team-based care. The State's solutions must support the unique needs of those who serve rural and mid-size communities.

Ensure that all savings realized by waiver activities stay within the Medicaid system and that federal funds generated by the assessment are not threatened. We urge the State to keep its commitment to the vulnerable, low-income persons served by the Medicaid program to ensure that the waiver is not used as mechanism to shift health care resources to other general revenue fund requirements. Likewise, savings achieved by reform should not be shifted away from physician and hospital care, but rather reinvested into continued efforts to achieve value and efficiency by these providers.

Extend the timeframe and/or narrow the scope of the waiver initiative if the various principles outlined above cannot be achieved. We are very concerned that the ambitious timeframe and scope outlined in the Concept Paper could result in unpredictable and disruptive impacts on what is already a complex funding structure. We urge the State to devote sufficient time and implementation resources to ensure both success and fairness of this effort. If this cannot be assured, the State should consider reducing (or sequencing) the scope of the effort, limiting it, for example, to the synthesizing of the multiple HCBS waivers and programs addressed under Pathway #1.

HSHS appreciates this opportunity to comment and looks forward to working closely with the State as this process continues. Questions about these comments can be directed to Tim Eckels at Tim.Eckels@HSHS.org, 217-492-9158.